PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	295055		B. WIN	IG		C 10/11/2008	
	OVIDER OR SUPPLIER	N CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	the result of a Medica which was conducted 11, 2008. The censu survey was 93.	ficiencies was generated as are Complaint Investigation I at your facility on October s at the beginning of the					
	The findings and con by the Health Division prohibiting any crimin actions or other claim	clusions of any investigation shall not be construed as lal or civil investigation, as for relief that may be under applicable federal,					
F 225 SS=D	The following regulat identified. 483.13(c)(1)(ii)-(iii), (i) TREATMENT OF RE	c)(2) - (4) STAFF	F	225			
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for other facility staff to the or licensing authorities. The facility must ensinvolving mistreatment including injuries of unisappropriation of reimmediately to the acceptance of the staff of th	ure that all alleged violations nt, neglect, or abuse,					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		295055	B. WIN	G		10/1	1/2008
	NAME OF PROVIDER OR SUPPLIER COLLEGE PARK REHABILITATION CENTER			28	EET ADDRESS, CITY, STATE, ZIP CODE 856 E. CHEYENNE AVE. ORTH LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I .	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 225	through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in progressing to the administrator or representative and to with State law (includ certification agency) vincident, and if the all	rocedures (including to the ification agency). e evidence that all alleged hly investigated, and must ial abuse while the gress. stigations must be reported	F	225			
	by: Based on interview, review, the facility fail of a thorough investig unknown origin for 1 in Findings include: Resident #1 Review of the record 48 year-old female which diagnoses included Mental Retardation, and Weakness. Document Review	resident (#1). revealed the resident was a no was admitted on 5/27/08 ing Anoxic Brain Injury,					
		the initial self report was lity which indicated Resident					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295055				C 10/11/2008	
	ROVIDER OR SUPPLIER	N CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 1856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030	1000	2000
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	The initial report indic - "Pt (patient) was be (certified nursing assi complained of pain in by nurse after she ye Patient checked on fr and was sleeping. Damorning care, pt yelle (immediate) x-ray cor attached. Pt sent to (medical doctor) and - X-ray results dated "Results: There is a f proximal tibia with mi and ankle joints are in Osteoporosis is preselower leg fracture as present This report radiographic examination is The final one page rerevealed: "This is our final concevents surrounding the able to determine that fracture relating to os x-ray dated 10-10-10-10 attached to the patient, and refer this patient, and refer this patient, and refer the complex complex to the patient, and refer this patient, and refer the pain in the complex complex to the patient, and refer this patient, and refer the complex com	cated: ing transferred by CNA istant) when patient in her leg. Patient assessed illed my knee, my knee. requently throughout notes ay shift transferring pt for red out again. STAT impleted. Copy of report acute care hospital) per MD family directive." 10/10/08 at 11:04 am racture involving the ild displacement. The knee intact in alignment. rent. Conclusion: Acute right described. Osteoporosis is is based solely upon the action. Correlation with the is essential." report dated 10/23/08, clusionAfter investigation of nis fracture, we have been t this was a spontaneous teoporosis as noted on the (The x-ray was actually have further identified areas and to assessment skills and interviewing staff who cared residents residing at (the o determine there was no ed."	F	225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		295055	B. WIN	B. WING		C	
	ROVIDER OR SUPPLIER			:	REET ADDRESS, CITY, STATE, ZIP CODE 2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030	10/1	1/2008
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 225	evidence of the inves statements, possible timeline. There were recurrence, no docum with the hospital to er radiological findings were recurrence, no docum with the hospital to er radiological findings were recurrence and record Review. Record Review Nurse's notes indicated and the state of the state	tigation such as, interviews, causes of injury, and a no measures to prevent a nented evidence of follow-up insure correlation of with the clinical exam. Entered patient room after ut in painful screams. Fied nursing assistant) to bed. When asked what in dishe didn't know at this ing on side of bed, right foot eft leg up in air indicating the checked ROM (range of toot. At this time asked if it ed it was all right. CNA	F	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
		295055	B. WING		10/11/2008	
	ROVIDER OR SUPPLIER	N CENTER	28	EET ADDRESS, CITY, STATE, ZIP CODE 856 E. CHEYENNE AVE. ORTH LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETION DATE
F 225	swelling at and above and observed was paneeded x-ray. Call pl made." Subsequent r was placed on bedrewere completed. At 1 notified of the resider the x-ray result disclophysician was inform to be sent out to the resident to be sent out to the resident assessment of her pathology and also at 4 thorough assessment documented the resident reatment for a total of the right leg. Interview On 10/11/08 at 2 pm, face-to-face interview - "Last Thursday 10/9 (Resident (Res) #1) Lest Thur	e knee. Patient wrenched hinful. Determined patient laced and request was notes indicated the resident st until the x-ray and results 2:00 pm the family was at's incident and at 2:00 pm used a fracture. The led and ordered the resident hospital. 9/08 through 6:20 am on went without a thorough ain complaint (at 6:30 pm on am on 10/10/08, no the was done when it was dent cried out) which delayed of 12 hours for the fracture of the revealed the following: 8/08, came in on swing shift. It is all yields and watch TV. It is and watch TV. It is to be changed?' Said she was the to wait until dinner time. It is she wanted to lay down. It is was transferring, time she screamed. I called maybe she has a cramp and chick the right leg she is) no swelling, no	F 225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295055	B. WIN	B. WING		C 10/11/2008	
	OVIDER OR SUPPLIER PARK REHABILITATIO	N CENTER	I	:	REET ADDRESS, CITY, STATE, ZIP CODE 2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030	10/1	172006
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		.D BE	(X5) COMPLETION DATE
F 225	then she screamed in On 10/11/08 at 3:30 pinterview revealed the sitting on the side of the sitting of the sitting on the side of the sitting of the sitting of the sitting on the sitting of the sitt	s #1) legs up into the bed, in pain" om, Emp #2 via telephone e following: scream and (Res #1) was the bed and she said 'What d) I don't know. Emp #2 ssuming she had a cramp of leg was on the floor to me and (Res #1) was en (CNA) needed to change and I told the charge nurse g and swelling of the right done a better exam (when implaint of pain)" ew stic radiological ad CT raphy) results revealed: (nee Series History: Fell bial plateau fracture which imal tibia." the right lower leg without in: cture of the proximal tibia, an (and?) involve the lateral eximal fibular head, which proximal tibiofibular a."	F	225			
	was:						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		295055	B. WIN	B. WING		C 10/11/2008	
	OVIDER OR SUPPLIER PARK REHABILITATIO			1	TREET ADDRESS, CITY, STATE, ZIP CODE 2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030	<u> 10/1</u>	1/2008
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page 6		F	22	5		
	tibia fracture. 2. Osteopenia and os 3. History of anoxic e 4. History of mental re Hospital Staff Intervie On 11/24/08, the followere conducted via te At 9:04 am, Physiciar regarding Resident # - "The tech (radiology 'fall' down to clarify thanybody to determine - "There was no sponof injurywith a fractusually you have a frate twist to the knee duwas a trauma caused caught or twisted in stransfer" At 10:55 am, Physiciar regarding Resident # - "The fracture can occan't be sure what the minor trauma was detried to get up and fel itself maybe caught fall but if they say 'vhappened,' that's stransfer"	etardation." www. wwing individual interviews elephone: a #1 indicated the following 1's right leg fracture: technician) may have put e history, but I did not talk to e that a fall took place" taneous break with this type ure from osteoporosis acture with no trauma With e to the spiral fracture this I possibly if the foot got something during the an #2 indicated the following 1's right leg fracture: ccur from minor trauma I e mechanism of fracture but finitely done maybe she I not osteoporosis by a leg on something and a we don't know what inge could be physical be if there was evidence of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUIL			С	
295055 B. WING		j		/11/2008			
	OVIDER OR SUPPLIER PARK REHABILITATION	N CENTER		STREET ADDRESS, CITY, STATE 2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE	
F 225	" Generally, spontar compression fractures (patients) become at unusual for a patient osteoporosis with this honest with you, tryin accident and abuse, thistory of prior injuries	an #3 indicated the following 1's right leg fracture: neous fractures are is in the back and they risk for hip fracture. It's with osteopenia and fractured tibia I'll be g to differentiate between an he only thing would be a	F 2	225			
F 309 SS=D	provide the necessary or maintain the higher mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical,	F3	509			
	by: Based on interview at failed to initially conductive which contributed to a resident who sustained: Findings include: Resident #1 Review of the record 48 year-old female will	revealed the resident was a no was admitted on 5/27/08 ing Anoxic Brain Injury,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	295055	B. WING		10/	C 10/11/2008	
NAME OF PROVIDER OR SUPPLIER COLLEGE PARK REHABILITATION	285	ET ADDRESS, CITY, STATE, ZIP CODE 6 E. CHEYENNE AVE. RTH LAS VEGAS, NV 89030	<u> </u>	11/2000		
PREFIX (EACH DEFICIENCY			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLETION DATE	
hearing patient yell out Observed CNA (certific putting patient back to was wrong was stated time. Patient was sitting on floor and holding let pain was in left leg. I comotion)ankle and foot still hurt and she stated proceeded to put patient returned to another patterned to another patterned to patient's room if she was ok and she not in pain." - 10/10/08 2:00 am, "Compare and change diaper. We wand she was awake. Our sign of problem. Returned to another patterned to another patterned to another patterned to another patterned to and she was awake. Our sign of problem. Returned she was awake. Our sign of problem. Returned she was awake. Our sign of problem. Returned she was awake. Our sign of problem. Os 30 patient appears to she compared to and we went to check found nothing. When we went to check found nothing. When we bruise 2" (2 inches) be swelling at and above and observed was pain needed x-ray. Call pla made." Subsequent not set the subsequent not subsequent not subsequent and subsequent not subseque	d: Intered patient room after It in painful screams. It in painful sasistant) It bed. When asked what she didn't know at this ing on side of bed, right foot if leg up in air indicating the hecked ROM (range of lot. At this time asked if it it it was all right. CNA in the back to bed and I litent 2030 (8:30 pm) It to check on patient asked indicated she was ok and litent 2030 (8:30 pm) It to check on patient, observed in litent check on patient, observed in litent checked left leg and still no right leg and still no right leg and still no right leg and resting quiet. 0620 oncoming nurse of patient patient. Check left leg and checking right leg noted low knee on skin and knee. Patient wrenched inful. Determined patient	F 309				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295055	B. WING			C 10/11/2008	
	NAME OF PROVIDER OR SUPPLIER COLLEGE PARK REHABILITATION CENTER			2	REET ADDRESS, CITY, STATE, ZIP CODE 1856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	notified of the resider the x-ray result disclophysician was inform to be sent out to the horizon from 6:30 pm on 10/10/10/08, the residenthorough assessment delayed treatment for fracture of the right less that the right less than 10/10/10/10/10/10/10/10/10/10/10/10/10/1	2:00 pm the family was at's incident and at 2:00 pm sed a fracture. The ed and ordered the resident nospital. 9/08 through 6:20 am on the continued without a state of her pain complaint which is a total of 12 hours for the ed. Employee (Emp) #1 via the revealed the following: 1/08, came in on swing shift. It is usually sits and watch TV. It is usually sits and watch TV. It is usually sits and watch TV. It is to be changed?' Said she eat to wait until dinner time. It is wanted to lay down. It is was transferring, time she screamed. I called maybe she has a cramp and contract the right leg she is) no swelling, no ed the transfer and transfer she was OK but is #1) legs up into the bed, in pain"	F	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295055	B. WIN	G		C 10/11/2008	
	ROVIDER OR SUPPLIER E PARK REHABILITATIO		.	28	EET ADDRESS, CITY, STATE, ZIP CODE 856 E. CHEYENNE AVE. ORTH LAS VEGAS, NV 89030	10/1	1/2006
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.D BE	(X5) COMPLETION DATE
F 309	is wrong' (Res #1 sairubbed her left calf, a the left leg. The right nobody said anything sleeping till 4 am whe her (Res #1) diaper a (regarding the bruisin	d) I don't know. Emp #2 ssuming she had a cramp of leg was on the floor to me and (Res #1) was en (CNA) needed to change and I told the charge nurse g and swelling of the right done a better exam (when	F	309			